Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee Open Session

Minutes of the meeting held on 25th January 2022 at 9.30am, held via Microsoft Teams

Draft Minutes

Present:		
Sarah Talbot-Williams	Chair of Committee, Independent Lay Member, Patient and Public Engagement	STW
John Rushforth	Independent Lay Member, Audit, Governance and Risk (Chair)	JRu
Georgie Bigg	Health watch Bristol, North Somerset and South Gloucestershire	GB
Katrina Boutin	Clinical Commissioning Locality Lead, Bristol	KB
Colin Bradbury	Area Director for North Somerset	CB
Ben Burrows	CCG Clinical Lead Clinical for Governance and Quality	BB
James Case	Clinical Commissioning Locality Lead, South Gloucestershire	JC
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
Philip Kirby	Chief Executive, Avon Local Medical Committee	PK
Lisa Manson	Director of Commissioning	LM
Julia Ross	Chief Executive	JR
Rosi Shepherd	Director of Nursing and Quality	RS
Apologies		
David Clark	Practice Manager	DC
Jamie Denton	Head of Finance – Primary, Community & Non Acute Services	JD
David Jarrett	Area Director for Bristol and South Gloucestershire	DJ
Matt Lenny	Director of Public Health, North Somerset	ML
Jon Lund	Deputy Director Finance	JL
Alison Moon	Independent Clinical Member, Registered Nurse	AM
Sandra Muffett	Head of Clinical Governance & Patient Safety	SM
Michael Richardson	Deputy Director of Nursing and Quality	MR
In attendance		
Jenny Bowker	Head of Primary Care Development	JB
Sarah Carr	Corporate Secretary	SC

Debbie Campbell	Deputy Director (Medicines Optimisation)	DCa
Louisa Darlison	Senior Contract Manager Primary Care	LD
Vittorio Graziani	Interim Contract Manager Primary Care	VG
Bev Haworth	Models of Care Development Lead	BH
Sukeina Kassam	Interim Head of Primary Care Contracts	SK
Lucy Powell	Corporate Support Officer	LP
Kat Showler	Senior Contract Manager Primary Care	KS
Lisa Rees	Principal Medicines Optimisation Pharmacist	LR
Sarah Wallace	Deputy Head of Patient Safety and Quality	SW
Jacci Yuill	Lead Quality Manager	JY

	Item	Action
01	**Welcome and Introductions** John Rushforth (JRu) explained that Sarah Talbot-Williams (STW) was unable to join the start of the meeting due to a prior appointment. Alison Moon was also unable to attend and JRu would chair the meeting until STW joined. It was noted that Katrina Boutin (KB) would join the meeting. The apologies were noted.	
02	**Declarations of Interest** There were no other new declarations and no declared interests related to agenda items.	
03	**Minutes of the Previous Meeting** The minutes were agreed as a correct record.	
04	**Action Log** The action log was reviewed and due actions were closed. **Action 164 –** The action remained open **Action 267 –**The action remained open. **Action 271**– LM explained that discussions regarding Information governance issues relating to the App were being held with NHS Digital. The action remained open **Action 275 –** Jenny Bowker (JB) it was proposed that the revised PCOG Terms of Reference were shared with the Executive Team and that STW was asked to review and approve using Chairs Actions due to the timing of the next Primary Care Commissioning Committee. This was agreed. **Action 277 -** LM explained that a letter had been received from the national team. The action was closed. **Action 279 –** the action remained open **Action 280 –** Sukeina Kassam (SK) explained that contributors had been asked to include information about health inequalities in their sections. The action was closed. **Action 281 -** it was confirmed that estates were included in the report. The action was closed.	

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	All other due actions were closed	
05	**Any Other Business** There were no matters for any other business.	
06	**Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF)** Attention was drawn to the reported risks scoring15 and above. Two risks had been added to the CRR since its last review; a risk relating to a shortage of blood bottles and a risk relating to the digital referral service. It was noted that the risk score for the risk relating to blood bottles had been revised and was now below the threshold for the CRR. The digital referral service risk had been discussed at the Clinical Executive and it had been recommended to the Primary Care Commissioning Committee as being within its remit. It was proposed that a briefing paper on this risk was presented to the March Committee meeting. Geeta Iyer (GI) confirmed that David Peel, the clinical lead, would contribute to the paper and noted there were links to the Healthier Together Outpatient Board. The GBAF was highlighted and it was noted that the risk score for the risk relating to finance had been reduced as with the publication of the planning guidance. There were no questions. **The Primary Care Commissioning Committee:** • **reviewed and ensures that appropriate and effective mitigations were in place for risks reported on the CRR and GBAF specifically relating to the Committee's remit** • **Reviewed those risks recommended for closure to ensure the Committee was assured that the risk score had been sufficiently reduced** • **Considered whether the CRR and the GBAF were an accurate reflection of the risks brought to the committee's attention** • **consider whether other objectives and risks reported on the GBAF fell within the committee's remit**	
07	**Helios Medical Centre Update 2022** Vittorio Graziani (VG) took the Committee through the paper, setting out the context to the paper. The contract holder had formally notified the CCG of the termination of the contract due to retirement in October 2021 and formal notification was received in November 2021 that Mendip Vale, on behalf of the contract holder, would continue to provide services to registered patients up to 31st of March 2022. The Primary Care Committee agreed in November 2021 to a managed list dispersal. The benefits of the approach	

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	were set out in the paper. A project steering group had been established to ensure leadership and oversight of the list dispersal and a project plan was in place. It was explained that at the end of the process full report would be prepared outlining all issues and lessons learnt to inform any future similar exercises. The project plan was outlined in the paper and the mapping exercise and patient communications and engagement were highlighted as well as the Inequality and Quality Impact Assessment to be completed. It was noted that communications with the public were important, and the support provided to affected practices needed to be considered. Issues included the impact of estate and the financial impact of dispersal. The CCG team had worked with colleagues in the CSU to develop resources to support the tracking of patient transfers. The project implementation was highlighted. This included the transfer of complex and vulnerable patients to new practices and the transfer of patient records. VG drew attention to the communications and engagement plan, noting the importance of a proactive approach to encourage participation by those people likely to be affected. It was noted that a potential issue for some patients would be the discontinuation of homeopathic therapies which had been provided by the contract holder. JRu asked when the Quality Impact Assessment and Equalities Impact Assessment would be available. VG explained that the timetable for the communications and engagement plan was at page 9 of the paper and included the Equality Impact Assessment. LM explained that the plan was underpinned with detailed work developing the letters to patients, building on the learning from other similar exercises. The impact assessments would be undertaken during February. LM confirmed that the Impact Assessments would be presented to the next meeting of the Committee. Georgie Bigg (GB) commented on the involvement of Health Watch. SK confirmed that Health Watch would be invited to join the task and finish group. GB offered on behalf of Health Watch to review the letters. SK thanked GB and noted that the team had anticipated that Health Watch would help with the review. James Case (JC) asked if the impacts of the dispersal of patients on the estate of receiving practices had been assessed. SK	

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	explained this matter would be discussed in the closed session due to the confidential nature of the issue. Julia Ross noted that the list size was relatively small and it was important to manage the transfer as seamlessly as possible. There were no further comments. **The Primary Care Commissioning Committee noted the report**	
07	**Covid-19 Vaccination and Flu Vaccination Update** GI provided an update on the vaccination programme drawing attention to the slide deck. Over two million vaccinations in total had been administered in BNSSG which was a significant achievement. The number of booster vaccines administered between 13th and 31st of December had increased in line with national policy. The PCNs had delivered two thirds of the 200,000 boosters. The programme dashboard update provided details of vaccine uptake for the patient cohorts. Work to refine this data was on-going and would come to the next open meeting. The system remained on course for the third doses trajectory. The focus on the mandatory vaccination programme for healthcare staff. The team was working closely with the LMC to support practices and offer programme resources. The booster programme continued to be the focus for practices and the PCNs. Care Homes and house bound residents continued to be visited to ensure the most vulnerable populations were covered. A number of PCNs were supporting Sirona with the delivery of vaccinations in schools for the 12 to 15 year old cohort. PCNs continued to hold clinics for clinically vulnerable 12 to 15 year old. Clinics for clinically vulnerable 5 to 11 year old would commence. A roving model to reach into key communities had been piloted and was being developed to offer a wider model. The children's vaccination programme would continue to be an area for increased focus alongside the continued development to the communications plan. Sarah Wallace (SW) asked what percentage of the population was covered by the two million vaccinations. GI explained the population of BNSSG was approximately one million and the two million vaccinations included second and third doses. GI drew attention to the uptake in cohorts against the national average, noting that BNSSG benchmarked well. There were no further questions. Lisa Rees (LR) presented the flu' update report. Levels of flu' remained low in the south west. A number of cases had been	

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	reported in Wales and the situation was being monitored by the Health Protection team. An NHSEI survey of GP practices highlighted that the majority of BNSSG practices had planned flu clinics in place throughout December and an opportunistic offer in place with clear advice for patients on practice websites. Co-administration of the flu and covid vaccinations continued. Uptake was highlighted. Current data showed that the national ambition for over 65 years had been reached. Uptake for the at risk group was lower than target as was uptake in pregnancy. The rate in uptake in the 2 to 3 year old cohort had increased however continued to be below target. This was now an area of focus with national and local communications in place with nurseries and child minders to encourage uptake. LR highlighted that the most deprived communities continued to have the lowest levels of uptake. Outreach models to deliver the vaccine were in place and the flu vaccine was also offered at the UWE Mass Vaccination Centre. The School Immunisation Team continued to offer vaccinations in primary and secondary schools. LR drew attention to uptake by at risk clinical groups noting that a number of cohorts had high uptake levels potentially due to high contact levels with primary care providers. NHSE was considering the commissioning model for patients seen more frequently in secondary care services to ensure higher vaccination levels in these groups. Attention was drawn to the staff vaccination programme. Uptake was lower than the national ambition and discussions were being held with Trusts. There were potential information gaps where staff had received vaccinations through other routes which were not being reported to providers. New access to vaccination records would help resolve any reporting gaps. There were no questions. **The Primary Care Commissioning Committee noted the reports**	
08	**Winter Access and Escalation Plan** JB highlighted the range of schemes in place as part of the Winter Access plan and the additional schemes to be scoped. The teams were working with practices to support their understanding of the available data and the development of improvement plans. JB noted there were a number of schemes where uptake had been lower than expected. The GP Clinical Network aimed at GPs taking a career break or recently retired and offering the opportunity for remote working had received one response. The	

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	scheme was under review to identify further actions to improve uptake. JB highlighted the Health Inequalities Bid which was to be scoped further. A number of proposals sat under this bid which would be reviewed at the GP Collaborative Board. NHSE had supported the progression of these schemes. The Community Pharmacy Dermatology scheme was highlighted, this would need to be scoped against the dermatology planned care pathway and the two week wait pathways. As a result, this scheme could roll over to later in the year and fallout of the Winter Access Plan. The risks and mitigations were detailed in the paper and included the risk of a staggered mobilisation of plans due to lead in times. The impact of the booster programme on practice capacity was also noted. JB noted there had been some issues for practices in accessing the new national online claims process. As issues were resolved a clearer understanding of the impact on activity and finances would develop. JB noted the fund was available until the end of March 2022. Attention was drawn to the Primary Care Escalation plan and the refresh of the Escalation Framework to support omicron surge planning. The Primary Care Locality Development was meeting twice weekly and practices were being reminded to renew business and business continuity plans. JB noted that One Care had worked with the group to refresh the framework and share it with practices. The Heads of Locality had supported the refresh of PCN and locality level plans. Situation reporting had been reinstated to understand absence and capacity issues. Consistent communications guides reflecting the framework had been shared with practices. System planning was highlighted. The operational plan process for 2022/23 had started and the plan would be submitted at the end of March. The narrative section, activity and workforce plan would be completed for the end of February. The key operational plan areas for primary care were set out in the paper. These included a greater role for community pharmacy, an expansion of the primary care workforce and addressing health inequalities. It was proposed to the Committee that the February seminar session was used to discuss the priorities for 2022/23. JR thanked the team for a comprehensive report. JR observed that the plan met the national directives and these needed to be	

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	placed into the context of local priorities, the development of ICPs and the primary care leadership role. It was important to this in the operational plan and also in the refreshed Long Term Plan. GPs needed to be embedded into the planning process in a meaningful dialogue. JR welcomed the proposed session in February and asked that the ICP leads were invited to attend. JB confirmed that discussions were in place with other teams and that the ICP development was an important part of the narrative. **The Primary Care Commissioning Committee noted the report**	**JB**
09	**Primary Care Strategy – PCN and Workforce Data** Beverley Haworth (BH) explained that the paper set out the context to the implementation of the strategy including national policy requirements. The change in the timescale for PCNs to identify a population experiencing inequality in health provision and/or outcomes, agree an approach to engagement and tackling the unmet needs of the population, from December 2021 to February 2022 was highlighted. A number of PCNs had started this work and the change in timescale now aligned with the system CORE20PLUS5 programme. BH drew attention to the significant workforce challenges and highlighted the support in place including staff sharing agreements, the system bank, the ongoing development of a Community, Primary Care and Social Care workforce bank and the continued support to PCNs in recruiting to additional roles. The role of the Training Hub was highlighted. Steven Locke, Kerri Magnus, and Sarah Ballisat from the Training Hub joined the meeting and gave a presentation explaining: • the purpose of the Training Hubs and the members of the team, • how the training hub supported the system, • the FCP and Advanced Practice pilots • The NHSEI/BNSSG and GPN Fellowship Programme and Supporting Mentors Scheme • Support for Non-Clinical Roles JR observed it was important that primary care and community care felt a level of ownership regarding the Training Hub and were able to lead and drive forward the work. The Training Hub would need to align with the GP Collaborative Board, and ICP development as part of the wider system of community care as well as PCNs and the focus on primary care. There was a conversation about the Training Hub procurement and it was noted that this was currently in the standstill period and the	

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	successful bidder was to be announced. It was agreed that there would be a future agenda item focused on the Training Hub and wider system alignment. JRu commented it would be helpful for future reports on the implementation of strategy to include the planned trajectory and progress map against this. BH drew attention to the report and highlighted that the PCNs had been invited to bid against unclaimed funds for the recruitment of Additional Roles. Bids were invited from all PCNs against the priority areas set out in the paper. Data quality continued to be a challenge and the CSU had been commissioned to support the Data Quality workstream with PCNs. All practices had met the target to map active appointment slot types to the national appointment categories and work with NHSEI continued to improve data quality and provide more real time reporting of activity. Work continued with the PCNS to ensure that monthly workforce returns were completed. BH highlighted that BNSSG had been successful in bidding for two projects looking at an enhanced health and wellbeing offer for community and social care staff and for a health and wellbeing support offer for staff working across primary care. These projects built on the Healthier Together Support Network. The networks website included a range of guidance on health and wellbeing topics, and printed materials were also available. Lunch and learn sessions for general practice had been hosted by One Care which provided an overview of wellbeing offers. BH explained that the next steps included continued support to PCNs for organisational development, and an evaluation of the impact of the Additional Roles. Katrina Boutin (KB) commented on the Additional Roles underspend noting that recruitment had been challenging, particularly for mental health roles. KB noted that as PCNs developed there were also issues regarding estates and IT. There were no further requestions and comments **The Primary Care Commissioning Committee noted the report**	**JB/BH**
08	**Primary Care Finance Report** Sarah Talbot-Williams chaired the meeting from this point. It was noted that finance colleagues were unable to present the paper. STW drew attention to the recommendations and asked if there were questions from the committee. There were no questions.	

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	STW asked colleagues that if they had subsequent questions to forward these to Jamie Denton who would pick these up at the next meeting. **The Primary Care Commissioning Committee noted:** • **the summary financial plan.** • **the key risks and mitigations to delivering the financial plan.** • **that at Month 9 (December), combined Primary Care budgets reported a £201k overspend before considering the risk pool. After applying the Risk Pool the net position was a £160k underspend.**	
09	**Primary Care Quality Report** Rosie Shepherd (RS) welcomed Sarah Wallace (SW) to the meeting. Jacci Yuill (JY) presented the paper an drew attention to the next steps which included working with primary care to deliver the vision for quality and safety. The CQC inspection report findings for Coniston Medical Practice were highlighted. Attention was drawn to the quarter two data for primary care incidents. Incidents were reviewed by the quality and medicine optimisation teams, themes and learning were shared in quarterly updates and meetings were held with providers to discuss and escalate concerns. The final slides compared reporting for quarter two against the same period in the previous year and identified incidents by category. JR asked if more up to date incident reporting data was available. JY explained that quarter three data would be presented to the March committee meeting. RS commented that the team would review the reporting intervals. There were no further questions. **The Primary Care Commissioning Committee noted the report**	**RS**
10	**Medicines Optimisation Report** LR explained the paper covered the quarter three period. Attention was drawn to the community pharmacy PGD service update. As at the end of November 2021, 8,570 PGD consultations had been provided. Plans would be developed to expand this service and the range of PGDs to other areas/conditions. More detailed data mapping was being undertaken to understand who was using the service and identify any inequalities in access to be addressed. The NHS Community Pharmacist Consultation Service – GP Referrals was highlighted. The pilot commenced July 2019 and positive feedback had been provided by practices and pharmacies. A further pilot had started in October with the South	

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	Bristol Urgent Treatment Centre referring minor illnesses to community pharmacies via electronic referral. This pilot was being positively received. A pilot to expand NHS 111 on line referrals to community pharmacy was planned to go live in mid-January. A series of polypharmacy medicines optimisation training events had been provided with the Training Hub. These had been well received. Attention was drawn to the antimicrobial stewardship update and the nationally reported increase in antibiotic prescribing for children. This had risen since the start of the pandemic. It was noted that the CCG continued to benchmark well as the second lowest prescriber of antibiotics in children aged 0-9 years old. The CCG continued to focus on this area to ensure appropriate prescribing. C. difficile continued to be monitored with cases reported at a higher rate since the start of the pandemic. A review of data had not identified a cause for the increased rates. A working group had been established to focus on the issue. STW noted the drop in C. difficile cases in November and asked if the cause had been identified. LR explained the data continued to be monitored to confirm whether there was an overall downwards trend. RS commented that the regional collaborative had considered the overall data and no rationale for the increase in cases since the start of the pandemic had been identified. This work was continuing. JC commented on the increased prescription of antibiotics for children and whether the changes to remote working and consultations had impacted on antibiotic prescribing. JC asked if the data could identify any trends linked to deferred prescriptions or telephone consultation issued prescriptions. LR commented this may depend on practice coding and agreed to investigate this. **The Primary Care Commissioning Committee noted the report**	
10	**Primary Care Contracts, Performance, Quality, Resilience and Premises Report** SK drew attention to the list closure application approved in December. The branch surgery closure approved in November was highlighted. The team anticipated a further application for a branch surgery closure in Spring 2022 and would continue to update the committee. Temporary branch closures related to covid-19 and temporary practice hour changes were noted. Primary care continued to support the Interim Accommodation Centres. CCG teams, together with the local authority and other	

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	partners, were supporting new hotel accommodations established in South Gloucestershire. Work to register patients had been undertaken and capacity and resilience support for practices was available. The Panel decision to refuse a Section 96 application was highlighted. A second application was under review. 10 practices were part of the General Practice Resilience Programme **The Primary Care Commissioning Committee noted the report**	
11	**Questions from the Public** There were no questions from the public.	
12	**Committee Effectiveness Review** STW invited colleagues to provide feedback on the effectiveness of the meeting. There were no comments.	
13	**Any Other Business** SK provided a further update on action 271 which related to concerns regarding unauthorised permissions to access data on the NHS App. The issue had been reviewed and it had been identified that the issue related to setting permissions within the GP record that required activation. Communications would be targeted at GPs to raise awareness. A further update would be made at the next committee meeting.	
14	**Date of next PCCC** Tuesday 29th March 2022	
15	The "motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business" was proposed by JR and seconded by GI	

Sarah Carr Corporate Secretary, February 2022